AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

Pursuant to Ohio Revised Code section 3721.13 and Ohio Revised Code section 3701-17-19, I hereby request and authorize _____ (the facility) to disclose my individually identifiable health information as described below.

_____	_____	_____
Resident Name	*Social Security Number*	*Date of Birth*

Name & address of person(s) or organization(s) requesting records, if different than resident:

_____

_____

_____

Name & address of person(s) or organization(s) to receive the records:

_____

_____

_____

- ❑ I will review the records at the facility.
- ❑ I wish to have the following records copied, and I will pick them up at the facility.
- ❑ I am requesting that the facility copy the following records, and send the records to the above address.

Information Requested (please initial)

I am requesting the following records from the resident's medical record that were created between ___/___/___ and ___/___/___:

___ Dietary Notes	___ Activity Notes	___ Nursing Notes
___ Physician Orders	___ Physician Progress Notes	___ Care Plans
___ Discharge Summary	___ X-Ray Reports	___ Lab Results

___ Other: _____

___ Other: _____

Purpose for which records will be used: _____

_____

Legal Authority for Request (please initial)

___ I am the resident noted above.

___ I am the resident's attorney-in-fact, and I have attached to this authorization a valid power of attorney or Durable Power of Attorney for Health Care (DPAHC) that grants me the power to request the resident's medical records. I understand that the resident's DPAHC is effective only when the resident's attending physician has determined that the resident has lost the capacity to make informed health care decisions.

___ I am the resident's legal guardian, and I have attached to this authorization a valid appointment of guardianship from a probate court.

___ If the resident is deceased: I am the executor/administrator of the resident's estate, and I have attached to this authorization a valid appointment as such from a probate court.

___ The resident has executed a legally binding instrument granting me the authority to obtain his/her medical records, and I have attached a copy of that instrument to this authorization.

___ The resident's legally authorized representative has executed a legally binding instrument granting me the authority to obtain the resident's medical records. I have attached a copy of the instrument granting me such authority, as well as evidence that the person who executed that instrument had the legal authority to do so, *e.g.*, a power of attorney or probate court order.

Understandings & Agreements of Requestor

1. This authorization is voluntary and I understand that the facility cannot condition treatment based on the signing of this authorization, unless the authorization is (a) for research-related treatment, or (b) solely for the purpose of creating health information for the use or disclosure to a third party.
2. This authorization will expire sixty (60) days from the date of my signature below.
3. I understand that I may revoke this authorization at any time by notifying the facility in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. I agree to waive all claims against the facility for the release of the requested information.
5. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by the facility if the recipient of the information is not a health plan, health care provider, health care clearinghouse, or a business associate that has a contract with the facility.
6. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services, or treatment for drug and/or alcohol abuse.
7. I understand that I must provide the facility with at least twenty-four (24) hours (excluding weekends and holidays) notice before coming to the facility to review records.
8. I understand that after I have reviewed the records, I must provide the facility with at least two (2) working days advance notice of any copies of the records that I would like to pick up at the facility.
9. I understand that if I request that records be copied and sent to me that the facility will make a good faith effort to send those records to me in reasonable amount of time.
10. I understand that if I wish to have copies of records made, then the facility will assess a fee for copying the records. I agree to pay the community standard rate for medical record copies established by Ohio law for copies requested from health care providers (*see Charges for Copies / Review of Medical Records*). If I request to have the records sent to me, then I agree to pay for the shipping of those records.
11. The facility will notify me of the total amount due for copying and shipping of the requested records; I agree that the facility will only send me the requested information once it has received payment in full for those costs.

_____ _____

Signature of person making request *Date*

_____

Printed Name of person making request